UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH DAKOTA
SOUTHERN DIVISION

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SALA NAAMBWE and YVETTE NIMENYA,

Plaintiff,

vs.

SMITHFIELD FOODS, INC.,

Defendant.

Case: 4:17-cv-04123-LLP

Avera Medical Group Behavioral Health
Sioux Falls, SD
September 24, 2018
4:35 p.m.

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D E P O S I T I O N O F

**DR. WILLIAM C. FULLER**

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APPEARANCES

Ms. Stephanie Pochop, Esq.
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for the Plaintiffs

Ms. Andrea R. Calem
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and

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for the Defendant

Also present: Sala Naambwe
Mark Cimeley



INDEX OF EXAMINATIONS



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INDEX OF DEPOSITION EXHIBITS



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Original Exhibits 1-6 were returned to Ms. Calem via USPS. The original transcript of this deposition was emailed to Ms. Calem.

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S T I P U L A T I O N

It is hereby stipulated and agreed, by and between the above-named parties through their attorneys of record, whose appearances have been hereinabove noted, that the deposition of **DR. WILLIAM C. FULLER** may be taken at this time and place, that is, at Avera Medical Group Behavioral Health Center, Sioux Falls, South Dakota, on the 24th of September, 2018, commencing at the hour of 4:35 p.m.; said deposition taken before Suzanne Brudigan, RPR, CSR, a Notary Public within and for the State of South Dakota; said deposition taken for the purpose of discovery or for use at trial or for each of said purposes, and said deposition is taken in accordance with the applicable Rules of Civil Procedure as if taken pursuant to written notice. Objections, except as to the form of the question, are reserved until the time of trial.

(Fuller Deposition Exs. 1, 2, 4, 5 marked.)

**DR. WILLIAM C. FULLER,**

called as a witness, being first duly sworn, testified as follows:

EXAMINATION BY MS. CALEM:

Q. Good afternoon, Dr. Fuller.



**A. Hello.**

Q. My name is Andrea Calem and I am an attorney for Smithfield Company Corporation and I represent Smithfield in connection with a lawsuit filed by one of your patients, Sala Naambwe. We are here to take your deposition, and I assure you, I will be as rapid as possible. I know it's late in the day.

Do you have an understanding of what this case is about?

**A. No.**

Q. Okay. All right. Can you just state your full name for the record, please.

**A. William Fuller.**

Q. What's your occupation?

**A. Physician, psychiatrist.**

Q. Where do you work?

**A. Avera Behavioral Health and University of South Dakota Sanford School of Medicine --**

Q. Okay.

**A. -- and I have some consulting locations that I go to, but.**

Q. Did you know that you've been identified as a witness in this case?

**A. I was subpoenaed.**

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Q. For this --
A. **For this deposition, I assume that.**
Q. Did you know that you had been identified as a trial witness in this case?
A. **No.**
Q. Have you ever been asked to give any expert opinions in this case?
A. **No.**
Q. Have you been asked to formulate any opinions relating to Miss Naambwe in this case?
A. **For purposes of what we're doing here today, no.**
Q. All right. Have you been deposed before?
A. **Yes.**
Q. How many times, roughly?
A. **I don't know. I don't know. Maybe 15. I don't know.**
Q. And were any of these depositions in connection with testifying as an expert?
A. **Yeah, a few of them were.**
Q. What courts were those in, do you know, do you remember?
A. **No, I don't really.**
Q. Okay. And the rest of the times that you were deposed, you were deposed as a treating physician?

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A. **Correct.**
Q. All right. Have you -- I take it you have not written any report relating to Miss Naambwe that is -- that you know is going to be used in the litigation?
A. **Correct.**
Q. And what states are you licensed to practice medicine?
A. **South Dakota, Iowa, Minnesota, Nebraska.**
Q. And you're duly licensed in each of those jurisdictions?
A. **Correct.**
Q. Licenses are current and on file at the appropriate places?
A. **Yes. Yes.**
Q. Within your practice of psychiatry, do you have a specialty?
A. **No.**
Q. Can you briefly describe your educational background for me?
A. **Went to undergraduate University of Nebraska Medical School, University of Nebraska psychiatry residency at Nebraska Psychiatric Association which is affiliated with the University of Nebraska and that would be it.**

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Q. Okay. How long was the residency?
A. **Three years.**
Q. And can you briefly describe your employment after you completed your residency.
A. **So at the completion of residency, I came to South Dakota full-time, employee of the State of South Dakota, and worked with University Physicians which was a practice corporation of the university -- or the medical school until 2002, which time I became a full-time employee of Avera and contracted with the State of South Dakota, so.**
Q. So 2002 you became a full-time employee of Avera?
A. **Correct.**
Q. Is your practice Avera Medical Group University Psychiatry?
A. **Yes.**
Q. Is that a separate business entity within Avera?
A. **No, I don't believe so.**
Q. Is it associated with any university?
A. **University of South Dakota Sanford School of Medicine.**
Q. Okay. And do you work at Avera full-time?
A. **Well, yeah, I'm a full-time employee, correct, but I do some consulting so I'm not actually here**

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**probably about a third of the time, I guess, yeah.**
Q. All right. And where is the consulting that you do?
A. **At Bethesda Counseling which is in Sioux Falls and Orange City, Iowa, and Southwestern Mental Health Center which is in Luverne, Pipestone, Worthington, so.**
Q. Approximately how many hours a week are you at the medical -- the University Psychiatry Group here?
A. **Probably about, I'd say, ten hours a week.**
Q. What's your current patient load here?
A. **Patients I see independently of the residents is probably, like, 25 patients is all. The rest of them I see with psychiatry residents.**
Q. Do you have a private practice separate and apart from any of these other entities, Avera and your consulting jobs?
A. **No.**
Q. So you see approximately 25 patients independent of residents. Is that for medication management?
A. **That and psychotherapy, yeah.**
Q. So you do both?
A. **Yes.**

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Q. And are you ever asked to see a patient purely for diagnostic purposes, forensic purposes, for litigation?
A. **Not for a long time.**
Q. And do you have privileges -- Obviously you have privileges at the hospital associated with Avera.
A. **Uh-huh.**
Q. Any other local hospitals?
A. **Sanford and Avera in Mitchell and Yankton and couple hospitals in Minnesota.**
Q. These are all -- Okay. That's a lot of hospitals.
A. **There you go.**
Q. So they are not only in South Dakota but the other jurisdictions in which you're licensed?
A. **Well, I don't have any privileges in any Iowa hospitals that -- Well, take that back. I'm not sure about that.**
Q. Okay.
A. **I did have affiliation with a hospital down by Orange City, but I think I maybe dropped off of that one.**
Q. Do you have any questions about the deposition process? You've been deposed many times before, but is there anything about the process or the

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case that you want to ask me before we go further?
A. **Not really, no.**
Q. You're here today because you were served with a subpoena, correct?
A. **Correct.**
Q. I'm handing you what's been marked as Exhibit 1 to your deposition. Can you take a look at that and tell me if that is the subpoena with which you were served?
A. **I believe so, yep.**
Q. And is -- There's a page at the end, I believe, which has your signature on it acknowledging receipt of the subpoena?
A. **Correct.**
Q. And that's your signature?
A. **It is.**
Q. All right. As you sit here today, do you have an independent recollection of treating Sala Naambwe?
A. **Probably not, that's not assisted by, you know, reading the records.**
Q. Before you came here today, did you read Miss Naambwe's records?
A. **Yes.**

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Q. You were asked to bring documents to the deposition. Avera has previously produced to us what I believe to be are the complete records of her treatment at University Psychiatry. I'm showing that the last date of treatment, the last report is in April of 2018. Is there anything after that?
A. **Yeah, I believe so.**
Q. Are those the records that you brought with you today pursuant to the subpoena?
A. **Yeah.**
Q. Okay.
A. **They're probably duplicates of mostly, maybe not the last note. 9-13-2018.**

MS. CALEM: May we go off the record for a minute so I have an opportunity to look through these records.

(An off-the-record discussion was held.)

MS. CALEM: Let's go back on the record.

I would like to take all of the documents that Dr. Fuller has produced here today and as a group we'll make them Exhibit 6, including the CV.

MS. POCHOP: Can I get a copy?

MS. MARSO: Right now or with the

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transcript?

MARK CIMELEY: I can get you a copy.

MS. POCHOP: Can I have a copy during this?

(Fuller Deposition Exhibit 6 marked.)

MS. CALEM: So, yeah, we're going to need a copy of this file. I'm going to put that in front of you but just keep it all together.

MS. POCHOP: Can we send it with him to get a copy while we're doing this?

MS. CALEM: Would you mind?

MR. CIMELEY: No.

BY MS. CALEM:

Q. There are several -- I have reports that were produced showing several visits by Miss Naambwe to your practice and you have produced one more. So I'm going to show you what I believe to be the four reports that I have -- And we don't have the page from that?

MS. MARSO: We're waiting for a couple pages.

MS. CALEM: We're waiting for it, I'm sorry, Doctor. I'll just use my copy so that would be Exhibit 3.

(Fuller Deposition Exhibit 3 marked.)

Q. All right. So these four reports, if you could

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take a look at them. Those are the reports I have. I just want to run through them briefly. The first one that I have, it has the Bates numbers in the bottom right-hand corner of the pages 22 to 26. Do you see down at the bottom right-hand corner? Is that numbered 22 through 26?

**A. Yes.**

Q. Okay. This appears to be a visit that Miss Naambwe had to this practice. Can you tell meet the date of service, the date of the visit?

**A. 5-9-2018.**

Q. And she saw --

**A. Correction. 5-9-2017.**

Q. Okay. And at that time she saw Dr. Makar -- is that how you pronounce it?

**A. Yes.**

Q. -- and yourself. Dr. Makar was a resident?

**A. Correct.**

Q. And what is the usual procedure for a resident seeing a patient and being supervised by a physician such as yourself?

**A. So they see the patient and they formulate their opinions and then they come and talk to the supervisor and present the case and their ideas**

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**and thoughts about that, and then I go back with them and talk with them and the patient and so --**

Q. All right. And how --

**A. -- and I either agree with them or don't agree with them, but.**

Q. Okay. So in the exhibit before you, there's a note, supervisory note on the second page?

**A. Yeah, correct.**

Q. And it says that you saw is Miss Naambwe with Dr. Makar for supervisory purposes and you agree with her findings and conclusions?

**A. Correct.**

Q. And how long, approximately, do you spend with the resident and the patient together before writing this supervisory note?

**A. Meaning total with talking to the resident and then --**

Q. Talking -- Well, let's say with the patient. What is the total amount of time?

**A. That would be variable, you know, from probably five minutes to 15 minutes, something like that.**

Q. Okay. So it's the resident that really works all this up?

**A. Correct, yes.**

Q. And you look over it and make sure that you agree

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with the conclusions?

**A. Correct.**

Q. All right. And the second, the next exhibit there, Miss Naambwe saw Dr. Gaines and Dr. Bhatara I think that should have the numbers 19 through 21 at the bottom?

**A. 19 through 21, okay.**

Q. Do you have anything with 19 through 21 at the bottom?

**A. I don't think so, no. I don't think I have one with Dr. Gaines, basically. These are all Dr. Berney's, these three.**

Q. Okay. These are duplicates.

Let's look at the one. Can you tell me the date of service on that?

**A. That is 1-19-2018.**

Q. And Dr. Berney and Dr. Bharata saw the patient?

**A. Correct.**

Q. And you had no involvement in that visit; is that correct?

**A. Correct.**

Q. And I'm handing you this exhibit. Can you tell me what date of service that report reflects?

**A. 4-24-2018.**

Q. Okay. And did you see the patient at that time

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with Dr. Berney?

**A. I did.**

Q. Would it have been Dr. Berney who wrote up this report basically?

**A. Yes.**

Q. Okay. Were your notes made just in the standard ordinary course of your medical practice, your supervisory notes?

**A. Yes.**

Q. And is it the practice for all physicians in this group to write up their reports of their encounters with their patients?

**A. Yes.**

Q. Typically how long after the appointment or session are the notes written up?

**A. Mine are usually written on the same day as the service.**

Q. Do you know about the residents?

**A. Varies. You know, they can -- most of the time it would be the date of service but sometimes it may be four or five days later, week later, I mean.**

Q. Is there a rule about that?

**A. Not an exact rule, but, I mean, you can get in trouble if you're late with all your reports.**

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Q. Okay. And how are the reports stored? Are they stored electronically?
A. **Yes.**
Q. Are they in hard copy anywhere?
A. **No. Unless you copy.**
Q. Unless you print it out?
A. **Yeah, right.**
Q. Do you have access to reports of other health care providers within the Avera system about Miss Naambwe?
A. **Yes.**
Q. And, likewise, would, for instance, Miss Olson who is --
A. **Uh-huh.**
Q. -- a physician's assistant who saw Miss Naambwe, would she have access to all of the reports about Miss Naambwe that are in the Avera system?
A. **Yes.**
Q. Do you recall if you reviewed any of Miss Naambwe's records before meeting with her for the first time?
A. **No, I don't remember. I don't recall.**
Q. Do you know how it was that Miss Naambwe came to the University Psychiatry Group?
A. **I believe she was referred from the primary care**

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**people to us for assistance with some symptoms she was having, you know.**
Q. Do you recall speaking to Kalee Olson about Miss Naambwe?
A. **No.**
Q. All right. So I want to take a look at the first visit where you and Dr. Makar saw Miss Naambwe. It appears that a history of the patient was taken. Is that standard practice?
A. **Yes, uh-huh.**
Q. And it would have been Dr. Makar who took that history?
A. **Correct.**
Q. Okay. Do you know if the patient was given any sort of physical exam?
A. **No, not that I'm aware of, although they do do -- usually do a portion of a neurological exam, you know, at each visit.**
Q. What portion is that?
A. **Well, musculoskeletal exam, examination of the cranial nerves with specific emphasis on a bunch of neurological symptoms that are common to psychiatric medication, you know, drug-induced symptoms, so we're looking specifically for those things.**

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Q. All right. Well, we're really here today because I want to ask about the diagnoses given to Miss Naambwe by this practice --
A. **Uh-huh.**
Q. -- including yourself and Dr. Makar and Dr. Berney. Would it be accurate that the resident would come to a conclusion about a diagnosis and a differential diagnosis and run that by you?
A. **Correct.**
Q. All right. In this case, we have the social history on the first report says: The patient came from the Congo in 2004 and has a history of physical abuse at a refugee camp and this is why she's sensitive to people touching her skin. She endorses nightmares and flashbacks.
Is this social history significant to the diagnoses that are in here?
A. **I believe so.**
Q. In what way?
A. **Well, I mean, because of past traumatic events are usually not completely forgotten. They're usually -- and they usually influence people's behavior and symptoms, you know, for a long, long period of time.**

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Q. Would that -- Well, let's just say, there's two diagnoses listed in the assessment section here. One is major depressive disorder recurrent severe with psychotic features and the other is PTSD.
A. **Correct.**
Q. The history of what happened in the Congo, is it relevant to both of those diagnoses?
A. **It could be for certain -- for the posttraumatic stress one, although most people who have that have depression, so.**
Q. They're comorbid, usually?
A. **Yeah, usually.**
Q. All right. Can you tell me what information in this report supports the diagnosis of PTSD?
A. **Just memories, flashbacks, hyperarousal, kind of sort of a vigilance, and then reactivity to environmental stimulus that reminds the patient of the past, basically.**
Q. When you say "hyperarousal", what do you mean?
A. **Easily startled, anxious, you know.**
Q. Easily irritated?
A. **Can be. Depends on the situation. Sometimes it's more just fears of, you know....**
Q. And when you say "reactivity to environmental stimulus", what are you referring to?

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**A. Something that reminds them in some fashion of what happened to them before.**
Q. Okay.
**A. They overreact to those kind of things.**
Q. So the history of the illness set forth in this report says the patient says she saw people following her that were not there. She says she saw herself having a gun and shooting them. The patient has been afraid in the parking lot. Whenever she sees people, she's paranoid that they might figure out her address. Thus, she is switching streets on her way home so that nobody can find out what her address is. Sometimes she's afraid in her room because people might sneak through the windows. She says she's having a lot of issues with male coworkers. She says she is afraid of people touching her skin and she gets paranoid that the people at work have a knife or a gun. And she has suicidal ideations.
Can you tell me how these symptoms support the diagnosis of major depressive disorder and PTSD?
**A. Well, I mean, those are like your paranoid symptoms which can be and often are a part of posttraumatic stress symptoms. And you can**

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**get -- also you can get psychotic symptoms in association with depression. So you might get a difference of opinion as to what the cause of them is.**
**I believe one of the residents gave a separate diagnosis for the psychotic symptoms as unspecified psychosis later on, you know, so you -- that's more of an uncertainty diagnosis. If you weren't sure, if you thought it was pretty directly linked into posttraumatic stress, then you would give it that diagnosis.**
Q. Well, there's several differential diagnoses --
**A. Yeah.**
Q. -- including mixed personality disorder, panic disorder, paranoid personality disorder, delusional disorder. Do you know if, in fact, Miss Naambwe was actually diagnosed with any of these?
**A. I don't believe so, no. You know, a lot of delusional disorder, no, most of those not anyway.**
Q. I'm sorry?
**A. I say most of those no.**
Q. Okay. I believe there was a new diagnosis in the last report that you produced but we don't have

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that, that's getting copied, so we'll go back to that.
What is major depressive disorder?
**A. It's just -- it's depression that's generally has defined onset, may or may not have a clear stress precipitating the depression but the symptoms are severe and present most of the time for a definite --**
Q. And you -- I'm sorry, go ahead.
**A. It's just a certain length of time they're supposed to be present, yeah.**
Q. All right. And the diagnosis here is major depressive disorder recurrent severe with psychotic features. And what does "recurrent" mean?
**A. It means there's a prior episode of depression.**
Q. And what are the criteria for a major depressive disorder in terms of how many episodes and the length of the episodes of depression?
**A. For it to be called recurrent, you have to have two episodes of it that were judged to be major -- a major depressive episode, because you can have a major depressive episode that isn't recurrent as a single episode.**
Q. So when you say -- Does recurrent, then, imply

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that there are certain periods of time when the patient is not suffering from any sort of depression?
**A. Yeah. There would be intervals where there wouldn't be depressive symptoms.**
Q. And --
**A. Although you can have comorbid things, so you could have posttraumatic stress symptoms that are continuous and episodes of depression on top of that.**
Q. It's hard to tease them apart, then, isn't it?
**A. Yes, very much so.**
Q. When you say psychotic features, what do you mean?
**A. That means having delusions or false beliefs or hallucinations or bizarre or unusual behavior, I guess, could be psychotic features.**
Q. All right. And what in this report substantiated or substantiates the diagnosis of major depressive disorder with psychotic features?
**A. Just symptoms of major depression and accompanying, you know, delusional and hallucinatory symptoms.**
Q. So a patient comes in with delusional and hallucinatory symptoms. How as a physician do

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you determine what is accurate about what the patient is telling you versus what is not accurate in those circumstances?

**A. You mean -- well, usually try to get as much history from collateral resources as possible. Sometimes they're the records of other physicians, but mostly it's family members or significant others that we get the history from. Could be, you know, jail records or whatever, you know.**

Q. With respect to Miss Naambwe, did you speak to anyone from her family about her symptoms?

**A. I believe, yeah, on several occasions there was another person present, but.**

Q. And who was that?

**A. Well, I don't remember the name of the person exactly, but.**

Q. It was a relative?

**A. Yeah.**

Q. And did you -- did you yourself speak to this relative?

**A. Well, briefly. Mostly the person was in the room when they were describing what the symptoms were and the case was, and there was some occasional references for confirming information but there's**

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**language differences so a lot of it was probably what was being -- trying to figure out what was being said as much as....**

Q. I see. Was this person Miss Naambwe's son?

**A. You know, I don't remember, to tell you the truth.**

Q. That's all right.

**A. And --**

Q. Go ahead.

**A. -- I would have to look at the records to see who it is, yeah.**

Q. Okay. You -- you did review these records before you came here today?

**A. To some extent. Not extensively, though.**

Q. Okay. Did you or anyone in the practice speak to anyone at Miss Naambwe's place of employment?

**A. No.**

Q. Did you review any files from her employment?

**A. No.**

Q. Did you review files from other medical providers?

**A. Yes.**

Q. Which ones?

**A. The family practice people.**

Q. And that's --

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**A. Dr. Olson primarily, you know, but there was Dr. Jensen.**

Q. Dr. Jensen?

**A. Yeah. I believe that's a therapist from family practice.**

Q. And what was the date of the report that Dr. Jensen wrote that you might have reviewed?

**A. 3-20-17.**

Q. 3-20-17. Did you review any reports of emergency room visits or notes?

**A. No, I don't think so.**

Q. All right. There's -- on the first page of the document that describes the first visit, there's a reference on the bottom LSS Clinic AMB report, bottom right. Do you see that?

**A. On the -- the visit of Dr. who and what date?**

Q. If you just look at the bottom right and there's a reference to what looks like another report, clinic -- or is this your report? I didn't know if that was something different or not.

**A. You mean of this talking about a report from LSS, that's Lutheran Social Services --**

Q. Yeah.

**A. -- counseling agency.**

Q. It is talking about another report?

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**A. Well, if it says LSS, that's what that would be, I believe.**

Q. Okay. Do you remember what information you received from that report?

**A. No.**

Q. All right. So psychotic feature denotes a break from reality; is that correct?

**A. Correct.**

Q. And typically how long do they last in a situation like this?

**A. Well, hard to say how long it would last, you know.**

Q. Did you -- do you have a sense for how long Miss Naambwe's psychotic feature would last?

**A. No, not really. It's -- because you can have the onset of more serious illness, you know, such as schizophrenia can present for the first time. You know, sometimes it presents right and then it can continue indefinitely.**

Q. Yeah. I did notice that on the last report which I'll have -- which is part of the group of papers that you produced, there's a differential diagnosis of schizophrenia.

**A. Uh-huh.**

Q. Do you know if that diagnosis has been confirmed?

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**A. I don't believe so.**
Q. So with Miss Naambwe, you had her son with her at one visit so you could corroborate some of the symptoms she's describing, correct?
**A. Right.**
Q. But outside of that, you don't have any information about her interactions with others; is that -- is that accurate?
**A. Other than what she's reported to other people.**
Q. Okay. So when Miss Naambwe comes in and says something like she's being repeatedly sexually assaulted at work and her supervisor refuses to do anything about it, is that something that you take at face value? Do you believe that statement?
**A. We try to get as much information about what actually happened as we can, you know, rather than take an abstract statement like that, so.**
Q. Do you remember what information Miss Naambwe gave you about being sexually assaulted at work?
**A. I was -- I can remember actually trying to figure that out and it was difficult to do so at the time.**
Q. Why was it difficult, language barrier?
**A. Partially, yeah. And --**

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Q. There is a reference in these reports to Miss Naambwe being a poor historian. What do you understand that to mean?
**A. That means you can't understand the history that she's giving you.**
Q. And why, because it's confused? Why might you not understand it?
**A. Well, could be language barrier. Could be the way a person recalls and describes things in the past, you know, so.**
Q. So you try to get as much information as possible about an incident the patient describes. To really, you know, determine whether it was true or false, you would have to consult other people, for instance, the people she talks about in the workplace. You did not do that?
**A. No.**
Q. Throughout these reports, there seems to be a theme of Miss Naambwe reporting improper sexual activity at work, somebody rubbing up against her, somebody trying to touch her vaginal area, somebody elbowing her. Does this -- did you corroborate any of those statements?
**A. From her -- like, her work place, you mean?**
Q. Yeah.

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**A. No.**
Q. Would Miss -- the fact that Miss Naambwe has PTSD stemming from her experience in the Congo, might that influence her perception of events in the workplace?
**A. Yes.**
Q. Might that cause her to misperceive --
**A. Yes.**
Q. -- actions?
**A. Uh-huh.**
Q. Miss Naambwe's had several clashes with workers, with coworkers and supervisors and that's led to what -- to the lawsuit today which is a discrimination lawsuit, race discrimination and retaliation. The diagnoses that she has been given, would they -- would these conditions tend to make workplace relationships a little more difficult?
**A. Well, they could, yes.**
Q. In what way?
**A. Well, just that she could be on guard, you know, hypervigilant, worried about being mistreated and overreacting to perceived mistreatment, you know.**
Q. So, for instance, if someone brushed by her and she reported that as a sexual assault, would that

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be consistent with PTSD syndrome?
**A. Could be, yes.**
Q. What -- Have you formed a belief about Miss Naambwe's reports that coworkers are trying to kill her?
**A. I didn't assume that that was true at the time, no.**
Q. That's part of her psychotic symptoms?
**A. Yeah. Her paranoid thinking, I would say, yeah.**
Q. Are you expressing any opinion with regard to Miss Naambwe as to the cause of her PTSD and major depressive disorder?
**A. Well, no. I mean, I don't have enough detail to -- about history in the Congo to know for sure.**
Q. So you say you don't have enough detail to know for sure the cause of her illnesses --
**A. Yeah.**
Q. -- is that accurate?
**A. Yes.**
Q. Okay. So you're not offering an opinion to -- that says with a reasonable degree of medical certainty that there was a particular cause for any of these illnesses. Is that accurate?
**A. I don't know. I think more accurate would be I**

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don't have enough detail about events that happened to her to know how much of it is directly related to traumatic incidents and how much is kind of an elaboration or kind of a paranoid thinking process or hallucinatory process so where the line changes there.

Q. Okay.

A. I don't think I have enough information to say for sure on that, although it does appear that a lot of things that she was thinking were not possible, so it does seem like those were psychotic symptoms, but exactly what did happen and didn't happen is always really hard to figure, you know.

Q. So -- so but you're not -- just to confirm, you're not going to testify in this case about any opinion about the cause of her illnesses. Is that accurate?

A. There's -- there's really only one thing in these records that makes you wonder and that's several references why these other clinicians that were seeing her said that someone was transferred or left the immediate workplace that she was in and that her symptoms dramatically improved when that happened. Several clinicians said that so it

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leads me to believe that somebody in her workplace was doing something, either that she was overreacting to it or else actually did something that she was reacting like most people would and that that person leaving really seemed to change her symptoms. So I believe there was either perceived or a real thing with another person.

Q. But you don't know if it was a perceived thing or a real thing?

A. No, I don't. I mean, she said a bunch of stuff about it, you know, like she went to her superiors and they wouldn't listen to her and this person was a friend of the supervisor and a bunch of stuff like that that would make you really wonder but, no, I don't have enough information to know for sure.

Q. All right. And, in fact, her paranoid symptoms could have preceded these events with the coworker, correct?

A. Sure.

Q. And had influenced her perception of what they did?

A. Yeah, could have been like he didn't do anything, she just imagined he was doing things. But,

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either way, she seemed to respond real positively when he was out of the picture.

Q. She reported that he had been fired for sexual assault. Do you know if that was true or not?

A. I do not. I would think probably not but maybe, you know. I mean, I didn't think that was probably true, but.

Q. Okay. And the report that she was doing better came roughly in 20 -- Well, let me get the date right. Well, strike that. After she reported feeling better because this individual was gone, there were additional relapses into --

A. Continued symptoms.

Q. Continue symptoms?

A. Yeah.

Q. All right. And have those continued as far as you know through the recent consultation this practice has had with her?

A. Yes.

Q. What do you recall in these reports about Miss Naambwe's compliance with her medication regime?

A. I think she's pretty compliant, other than one of her medications was very expensive so she didn't want to take it. The Lurasidone or Latuda,

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they're both antipsychotic --

COURT REPORTER: I'm sorry, say those again.

THE WITNESS: Lurasidone, L-u-r-a-z-i-d-o-n-e [sic].

COURT REPORTER: Thank you.

BY MS. CALEM:

Q. Well, there are numerous references in these reports to noncompliance with medication. For instance, in the last -- can you look at the April 2018 visit? Do you have that document in front of you?

A. April -- yep, I do.

Q. April 2018.

A. Right.

Q. Okay. And there's a reference in there to her using Seroquel but only every few days.

A. Uh-huh.

Q. What symptoms does the Seroquel treat?

A. It's an antipsychotic, but it also has a lot of antianxiety symptoms frequently used for people that are having trouble sleeping.

Q. Okay. On the second page of that report, Miss Naambwe says when she is taking the Seroquel, she's not angry or yelling and it helps with her concentration, she does better at work.

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A. **Uh-huh.**
Q. And, however, it does say she's only taking it every third day and then she starts having problems.
A. **(Indicating).**
Q. Would this failure to comply consistently with the Seroquel prescription, could that lead to greater incidents of workplace conflict?
A. **Well, yeah, she could have more symptoms, yeah, for that.**
Q. And if she was noncompliant in general with medication designed to treat her mental illnesses, could that have an adverse effect on her interactions with people in the workplace?
A. **It could.**
Q. Do you have any -- when you say that you believe she was mostly compliant, on what do you base that?
A. **Well, I mean, I think she was -- had tried to take all of the medications that they were prescribed. It's not terrifically unusual for psychotic patients to not take their medications all the time, especially when they're first diagnosed. It's actually true of all people with all medications but, so.**

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Q. Do you know, are you familiar with the fact that Miss Naambwe has high blood pressure?
A. **Yes.**
Q. And if she is not compliant with her blood pressure medication, might that have an effect on her mental and emotional well-being?
A. **Might. Headaches mainly is, I think --**
Q. Headache?
A. **-- was the symptoms that she had.**
Q. Okay. So if we look at -- I'm trying to find the date of this report. Can you tell me the date of service on this, of this visit?
A. **That was September 13th.**
Q. Of what year?
A. **'18.**
Q. 2018, all right.
So that's in the package that you -- that you received, Stephanie.
This is a report that we had not had previously. Dr. Nuss, is that how you pronounce it --
A. **(Indicating).**
Q. -- was the attending? And his -- is Dr. Nuss a man or a woman?
A. **A man.**

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Q. His diagnosis was psychotic disorder unspecified. Do you believe that the patient's symptoms support that diagnosis?
A. **Well, as I say before, that's a non -- a sort of like a transitional diagnosis usually or else the symptoms are unusual, they don't fit exactly any of the standard psychotic diagnosis. So, no, it doesn't surprise me that someone would give her that diagnosis.**
Q. All right. On the first page of the -- the September report, it says patient was last seen by Dr. Berney on June 22, 2018. At that time Latuda was discontinued due to cost and she was started on Risperdal one milligram twice daily. She was continued on Zoloft 100 milligrams and Prazosin two milligrams. Can you tell me what Risperdal is designed to treat?
A. **An antipsychotic medication.**
Q. And Zoloft?
A. **Antidepressant.**
Q. And Prazosin?
A. **It's for -- generally for nightmares.**
Q. All right. Patient indicates that she's been taking the Risperdal once in the evening but does not take the medications daily. Would that

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indicate noncompliance?
A. **Well, yeah, sure.**
Q. At this point in time in September of 2018, Miss Naambwe is still reporting paranoid symptoms, someone will kill her, someone is following her in a car, someone will bomb her house, and the food in the cafeteria is being poisoned, her food. Are you familiar with that statement?
A. **No, I didn't recall that.**
Q. Would a belief that the food in the cafeteria, her food in the cafeteria is being poisoned, would that be a symptom of a psychotic feature of her depression?
A. **Well, psychotic features of something, right.**
Q. If Miss Naambwe has reported at times that she loses track of time, kind of blanks out for maybe a minute or two, doesn't know where she is, is this a symptom of any of the illnesses with which she has been diagnosed?
A. **Predominantly posttraumatic stress disorder.**
Q. And how does that --
A. **I mean, you can have --**
Q. -- that --
A. **-- similar things with depression, yeah.**

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Q. Okay. And how do you define posttraumatic stress disorder?
A. **It's a syndrome that follows an identifiable stress that would cause anybody to have symptoms, basically, and the symptoms persist after the event and they're, you know, flashbacks, nightmares, hypervigilance, reactivity to stimulus, general withdrawal, emotional lability.**
Q. Can the symptoms sometimes emerge years after the incident happened?
A. **Sometimes, yeah.**
Q. Ms. Naambwe's testimony in her deposition was that she -- her symptoms were entirely due to this mistreatment at work, had nothing to do with her experiences in the Congo. What do you think about that statement?
A. **Well, I don't know. You know, I mean, obviously there's -- there's some things happening that are not only related to the workplace environment, you know, so.**
Q. So you would not believe that that was an accurate statement, would you?
A. **Well, I need a lot more information. It's possible that nothing happened to her in the Congo, you know, and I just don't know it, right,**

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**so.**
Q. Have you -- Well, in your views, could Miss Naambwe benefit from psychotherapy?
A. **Probably, if she had someone that could speak her language.**
Q. Have -- has she ever expressed an interest in it, to your knowledge?
A. **No, not to my knowledge.**
Q. Have you suggested it to her?
A. **No.**
Q. On these reports, there's a section that talks about insight. What does the word "insight" mean within the context of a report like that?
A. **Understanding of your illness, basically.**
Q. There are several references to Miss Naambwe having limited insight. Would you agree with that?
A. **Well, I don't know for sure on that.**
Q. Is there a test or an -- a test to measure insight?
A. **Mainly just talking to the person or interviewing them, almost always in cases like this. So there's different kinds of insight, right, knowing something's wrong with you, knowing that the doctor might help you, you know,**

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**understanding that perhaps some behaviors you have are subtly influencing someone else and that reaction to you may be what you're feeling, you know, as well as, like, a high level of insight. So there's -- there's a lot of different levels of insight. So generally with somebody who's psychotic, you're talking about do they know that they have psychotic symptoms that they may benefit from, you know, that they should take their medications to help those symptoms. That's usually the main thing, but there are people who know something's wrong, they just don't exactly believe the doctor's got it right, you know.**
Q. So there's sort of a continuum with insight?
A. **Yes, right.**
Q. I mean, some people might fully understand that they have a mental illness and there's some things that aren't there and other people would be in complete denial, those would be the two ends of the spectrum?
A. **Yeah. Yes.**
Q. And if -- when this report says Miss Naambwe's insight was limited, what do you think it means?
A. **I think it means that she doesn't understand some of the things that I don't understand, like what**

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**is causing her symptoms, where they're coming from, what's real, what isn't real, you know, whether or not people might actually be following her or not would be the kind of area I would say where her insight is limited or, like, this person at work was following her around outside of the workplace or, you know, that kind of insight.**
Q. I just want to go back to this first report. In one of these reports, Miss Naambwe denies being depressed despite her diagnosis. Does that reflect a lack of insight about her condition?
A. **I would think so, yes.**
Q. And if she -- in one of the reports, she reported that she believed people were poisoning her food in the cafeteria and said to the physician who she was speaking to, well, you don't know for sure that's not true, does that reflect lack of insight about her condition?
A. **I would say so, yes.**
MS. CALEM: Let's go off the record for a minute.
(A recess was taken at this time.)
MS. CALEM: Back on the record.
Are you able to render an opinion about

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whether or not Miss Naambwe was being truthful in reporting her symptoms, for instance, sleeplessness, crying, all of that?

**A. No. I don't have any -- any reason to think she wasn't being truthful.**

Q. Well, as a physician, how do you deal with that, then? You just sort of take the patients at their word?

**A. You generally do.**

Q. You mentioned that Miss Naambwe's son was at some of these appointments. Do you know if he corroborated any of the symptoms?

**A. Yeah, to some degree, yeah.**

Q. What symptoms did he corroborate?

**A. I don't know for sure. I just know he was there.**

Q. Okay. But you don't know for certain that he corroborated them?

**A. No. I wouldn't be able to testify one way or the other on that.**

Q. So you're sort of making at an assumption that, yes, he might have corroborated them but you don't know for certain, right?

**A. Right.**

Q. Okay. And do you believe that given the history, the resident had enough information to diagnose

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Miss Naambwe with PTSD and major depressive disorder?

**A. I don't know for sure actually, but -- but I would think so, yes.**

Q. Well, what are the criteria for PTSD? I mean there's a DSM definition for it; is there not?

**A. Sure.**

Q. What does the criteria usually, like, list? Two out of these five, three out of these?

**A. Yeah.**

Q. Do you know what the criteria are for PTSD --

**A. Well --**

Q. -- without looking at the DSM?

**A. Not in detail that way but, you know, the general idea and the symptoms that are present, you know, so.**

Q. Okay. So but in terms of Ms. Naambwe's symptoms, you can't say how many of the PTSD symptoms that are in DSM she actually had for what period of time; is that accurate?

**A. Well, I think we could say a lot of the symptoms that she did have. We don't -- what we don't know is the nature of the original, you know, traumatic event.**

Q. Well, she reported sexual abuse. Would that be a

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traumatic event?

**A. Yeah, sure, but we don't know exactly what happened. And so if it's a reliving or recreation of a past experience and you have someone with psychotic symptoms, then it's kind of hard to tell what's from posttraumatic stress and what's from maybe something else. So it's unclear in her case and it would be --**

Q. So it's the -- you're saying that it's not clear what disorder her symptoms result from in all cases?

**A. Yeah. Well, where -- where the line is drawn, I guess, between.**

Q. Okay. Does Miss Naambwe show signs of having some sort of personality disorder? It was in the differential diagnosis.

**A. Yeah. I don't think so, no.**

Q. And why -- why, then, was it in the differential diagnosis?

**A. Because it could produce these symptoms.**

Q. Okay. Would someone with a personality disorder tend to be untruthful in reporting their symptoms?

**A. Could be, depending upon the personality disorder.**

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Q. Well, what about mixed personality disorder?

**A. About which?**

Q. Wasn't the differential mixed personality disorder?

**A. Oh, mixed is....**

Q. What does that mean?

**A. That means the symptoms were for more than one personality disorder.**

Q. Can you define what a personality disorder is?

**A. Sort of a lifelong pattern of behavior that's maladaptive.**

Q. Maladaptive coping?

**A. Well, it could be a lot of different -- you know, like, there's obsessive/compulsive personality which is a pattern of being overly detailed or working too much and intolerant of other people's mistakes and errors and so forth and so on. And then it's maladaptive in a number of different ways, but it's not going to produce somebody who's not going to tell the truth, you know.**

Q. Okay.

**A. And there's antisocial personality which is a habitual criminal, of course, they're always untruthful, you know.**

Q. And what about, is there such a thing as a

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paranoid personality disorder?
**A. There is, yeah.**
Q. And can you explain how that manifests?
**A. Usually just kind of a very widespread distrust and friction with others based upon multiple different kinds of distrust and so those people are continuously getting conflict, you know, so they're oftentimes in lawsuits, paranoid personality disorders are.**
Q. Well, so is it possible, then, that that diagnosis also applies to Miss Naambwe, because based on what you just said, it's exactly what's happened?
MS. POCHOP: Well --
**A. Yeah, I don't think that's what she has, no.**
Q. Why not?
**A. Well, because I just don't think -- well, for one thing, you don't get psychotic symptoms, you know.**
Q. With the personality disorder?
**A. Right.**
Q. But could the personality disorder be comorbid with something that gave you psychotic symptoms?
**A. Sure.**
Q. Okay. So in terms of the symptoms she came into

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the clinic reporting, I just sort of want to nail down if you have any -- if you're giving any opinion or making any statement about the cause of them. You said you really can't determine what happened at work and you can't determine exactly what happened in the Congo. You talked about her feeling better when some coworker was supposedly fired which led you --
**A. No, I didn't say fired. It says it in the record, yeah.**
Q. Okay. That he supposedly -- that he went away so she was feeling better.
**A. Yeah.**
Q. So I guess I'm trying to figure out, what is the traumatic event? What are you saying is the traumatic event that has caused her PTSD?
**A. Well, I think the assumption is that before she got to the United States, that she was mistreated probably physically, likely sexually, and, you know, who knows what in terms of, you know, like, mental abuse or whatever and that that would predispose her to, you know, reacting to a lot of different situations with anxiety and depression and....**
Q. So you believe that it's more likely than not

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that the situation in the Congo was what created the PTSD symptoms?
**A. Right.**
Q. Okay. Are you saying that to a reasonable degree of medical certainty or just a more likely than not, you just don't know?
**A. I would say more likely than not, you know.**
Q. All right. What about the depression with the psychotic features, can you pin down a cause of that?
**A. Well, not usually. I mean, there's almost always biological factors involved in that particular disorder and that would be a need to have, like, a pretty good history of, like, her family tree and we would have to do some kind of translating the cross cultures as to what depression is and how that would be reported. And, you know, it would be difficult basically to know everything, but there always are biological aspects to it.**
Q. You don't have that information for Miss Naambwe, do you?
**A. No.**
Q. Okay. So can you state with a degree of -- reasonable degree of medical certainty that she has major depressive disorder with psychotic

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features?
**A. Well, I think that we can say that she has major depression. Whether the psychotic features are related to the depression or not is probably open to question.**
Q. Well, what else would they be related to?
**A. What could they be related to? They could be related -- be schizophrenia, there's a lot of people that are under stress, and when they have posttraumatic stress disorder will get transient psychotic symptoms, you know, so.**
Q. All right. So Miss Naambwe experienced an incident in the workplace where a coworker made racist statements to her. Are you expressing any opinion as to whether or not that might have caused any of her symptoms?
**A. I do not know.**
Q. You could not say, could you?
**A. No.**
Q. Would a person with PTSD and major depressive disorder have a harder time getting over something that bothered them in the workplace than people without those disorders?
**A. Yes.**
Q. Might they then -- Well, strike that. Do you

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intend to speak to any of Miss Naambwe's family members about her condition?
**A. In the future?**
Q. Yeah.
**A. Well, it kind of depends, you know. Like, it may be that I will not, in the ordinary series of events, have anything to do with the supervision of the current resident that's treating her.**
Q. So that means you don't know if you will?
**A. No, I don't. I don't know if -- but pretty likely that she is being seen -- or was seeing a resident that's mostly not here when I'm here and is supervised by Dr. Nuss so that's most likely what's going to happen.**
Q. So you don't necessarily anticipate being a part of Ms. Naambwe's treatment in the future?
**A. Right.**
Q. Does somebody with the conditions that Miss Naambwe's been diagnosed with tend to have a low self-image or self-esteem?
**A. Certainly can, yeah.**
Q. Do you know if that's the case with Miss Naambwe?
**A. No, I don't know.**
Q. Miss Naambwe, in an emergency room visit, said that a coworker coerced her into trying to touch

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his genitals and then went behind her and stabbed her with something and then an electrical shock went up her back. Would you consider this to be a description -- would you consider this description to be accurate that something like that really happened?
**A. Unlikely, yeah.**
Q. If Miss Naambwe told Ms. Olson that she will frequently see people across the room in flashes of light, is that evidence of a psychotic symptom?
**A. Yeah. That's very unlikely, I guess.**
Q. When she says a man at work is placing witchcraft spells on her, is that, again, symptomatic of her psychosis?
**A. Yeah. I mean -- I mean, I think the resident that reported that said they didn't know if that had something to do with cultural beliefs, but.**
Q. That was Ms. Olson. What does that mean?
**A. What? That means she doesn't understand the culture which she was raised in.**
Q. Okay. But in terms of this culture, someone who says that is generally thought to be exhibiting some form of psychosis, correct?
**A. Correct, yeah.**

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Q. So just to -- I keep circling back to this but I just want to be certain of this. You're not saying that a traumatic event at work caused any of these symptoms from Miss Naambwe, are you?
**A. Well, I don't know -- I don't know for certain. It does appear that some degree of anxiety was present, you know, related to the work situation and that that did get better, you know.**
Q. Okay. But -- but you don't know the circumstances behind that, correct?
**A. No.**
Q. And that getting better did not persist, right? She relapsed into psychotic symptoms, correct?
**A. I don't know that for sure, either --**
Q. Well --
**A. -- I mean, whether the getting better persisted or not.**
Q. Okay. Well, do you remember the date on which she said she was getting better?
**A. No. I mean, I could look it up.**
Q. Well, do you have it in your notes there?
**A. Do I have it in my -- no, I don't, really.**
Q. Okay. But assuming that she then relapsed and had further psychotic symptoms, would that tend to indicate that that stressor at work is not

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really the cause of her problems?
**A. Well, certainly not the sole cause of her problems, right, the only cause of her problems. She has other things happening.**
Q. And her perception of an event at work could have been distorted based on her symptomology, correct?
**A. Correct.**
Q. And do you have any idea of what traumatic event may have happened at work?
**A. Well, she says that -- that people said suggestive things to her and that she was touched in a sexual fashion and other things that happened that seemed like they probably didn't happen is basically the way it sounds to me, so.**
Q. And I think we discussed this before, but her reports of being touched and being sexually abused, could that -- those be influenced by her oversensitivity to touch based on what happened to her in the Congo?
**A. Could be, or could be totally psychotic and it didn't happen at all, you know. I mean, there's no way to know. I mean....**
Q. Early in her time at Smithfield, Miss Naambwe had a conflict with a coworker which escalated to the

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point where they had to be separated into different departments and then Miss Naambwe claimed that that coworker was trying to run her over with her car.

**A. Uh-huh.**

Q. What's your reaction to that report? How does it connect with the symptoms of the diagnoses?

**A. I mean, I don't know. I mean, I don't have any good answer.**

Q. You don't know if that's an accurate report or not?

**A. Well, yeah, I don't know anything about it.**

Q. Okay. Could it have been a symptom of her paranoia?

**A. Sure, could have been.**

Q. So, I mean, you know, the reports consistently refer to Miss Naambwe as someone who's a poor historian, whose insight is limited. Does that suggest that many of the incidents she relates are not, in fact, true?

**A. Not necessarily, but could.**

Q. It could?

**A. Yeah.**

Q. So it's possible that if you went into the workplace and talked to everybody who was

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involved in these incidents, you would find out that Ms. Naambwe's version of events did not tally with what they perceived to be real?

**A. Correct, yeah, could be.**

Q. If Miss Naambwe acknowledged that the information she gave her doctors about what was happening at work was not accurate, what would that tell you about her level of truthfulness?

**A. I mean, if she told me the things she told the doctors weren't true?**

Q. Well, let me go back and explain this. In her -- in Miss Naambwe's deposition, I asked her about a report that she gave to her doctor about being repeatedly sexually abused by a man who she'd accused of sexual harassment, and she conceded to me that, in fact, that report that she gave her doctor was not true, he had not repeatedly sexually harassed her. What does that tell you about her level of truthfulness in reporting her symptoms?

**A. I don't know. What did she say did happen?**

Q. She said that early in years before, he had pointed at his penis but otherwise had not touched her.

**A. Years before?**

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Q. She talked about an individual who in 2014 she believes pointed at his penis. She said he never touched her, never did anything else ever again after that but she told her doctors that she was being repeatedly sexually abused at work. What does that tell you?

**A. I don't know. That's weird.**

Q. It's weird. Does it suggest a level -- well, it certainly suggests a poor historian, correct?

**A. Yeah.**

Q. And does it suggest a level of untruthfulness?

**A. Well, I don't know. I mean, it seems unusual, right, in a number of different ways, yeah.**

Q. Are there people who exaggerate their symptoms when they go to the doctor and talk about them?

**A. Sure, yeah.**

Q. And how do you determine if somebody's exaggerating or not?

**A. You -- The only way is if you have confirming -- something that's confirming history one way or another.**

Q. And in this case, you don't have that, correct?

**A. No.**

MS. CALEM: Okay. Let's go off the record. I think I'm done.

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(An off-the-record discussion was held.)

MS. MARSO: Let's go on the record.

THE WITNESS: Yeah. On the record you were saying you didn't have much more to ask, right?

MS. CALEM: Right. But you were making a comment.

THE WITNESS: Yeah. I was just making an offhand comment.

MS. CALEM: Okay. Is it relevant to Miss Naambwe?

THE WITNESS: No.

MS. CALEM: All right. We're going to go off.

(An off-the-record discussion was held.)

MS. CALEM: Why don't you go ahead, Stephanie.

EXAMINATION BY MS. POCHOP:

Q. You haven't personally had a significant amount of contact with Miss Naambwe?

**A. Not much, no.**

Q. Okay. The contact you have had has -- you've observed that there's a language barrier for her?

**A. Correct.**

Q. How does her language barrier affect your ability to get a history from her?

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A. **Well, it's hard to get a description of events and understand exactly what she means.**
Q. Do you have a way of assessing how well she understands what you're relating to her in English?
A. **Not really, no. I mean, probably need a good translator, you know, in order to be able to understand anything.**
Q. Have you observed -- do you think that her level of education has -- creates a barrier in terms of her insight and understanding of her condition?
A. **Probably, yes.**
Q. And how -- how would that affect her ability to understand her -- have insight into her condition?
A. **Would make it certainly less -- less ability to communicate about it, for sure.**
Q. Okay. You mentioned that there's cultural differences that impact the ability to diagnose and treat Miss Naambwe. How does -- how do cultural differences figure into the evaluation and treatment that she's been provided here?
A. **Well, cultural differences probably make it difficult for the residents or myself or whoever attending to understand completely what she means**

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**when she says almost anything, you know.**
Q. All right. In terms of -- so you have a person that's difficult to communicate with and even just to really, like, literally understand what they're saying?
A. **Uh-huh.**
Q. Yes?
A. **Yes.**
Q. And can you tell me, then, what is the goal of the treatment that she's received here at Avera?
A. **Would be to decrease the amount of hallucinatory symptoms that she has, decrease the amount of overt paranoid symptoms that she was -- that she had, and improve her mood and probably reduce the fearfulness, anxiety.**
Q. In your treatment, do you think that her work environment figures into the symptoms that she is reporting?
MS. CALEM: Objection.
A. **Yeah. I mean, directly I probably can't say. Several of the residents and other doctors did, you know, so.**
Q. But when you reviewed -- I mean, you reviewed their notes because you were approving your residents' evaluation, right?

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A. **Yes.**
Q. What did -- what did -- what was the conclusion reached by the residents that evaluated her in terms of her work environment?
A. **I think they would -- they all thought that something was happening at work that was causing distress, a lot of distress, and I think most of them would say they don't know exactly what it was that was producing the distress.**
Q. In your experience as a treating physician, can a hostile work environment exacerbate PTSD symptoms?
A. **Sure, yes.**
Q. Can a hostile work environment exacerbate major depressive symptoms?
A. **Yes.**
Q. Would -- what kind of advice would you give a person who has PTSD and major depressive symptoms like Sala who reports feeling very stressful and having these incidents at work? What should she do on her day-to-day work life to try to make herself better?
MS. CALEM: Objection.
A. **Well, I mean, you would want, if possible, some kind of an environmental intervention, could be**

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**like a case manager or a home care worker or some kind of cooperation with the HR department at the work or something like that; you know, something that would -- could get a direct handle on what was going on and if there were any solutions that could happen within her environment that could make things a lot better.**
Q. Do you know what's been recommended to her in terms of when she believes these incidents have arisen at work, what medical advice has she gotten about how she should deal with them? She supposed to come here and talk to a physician or is she he supposed to talk to somebody at work? What's the protocol --
MS. CALEM: Objection.
Q. -- recommended for her?
A. **Yeah. The only person that really directly talked about that was the therapist, you know, said that she should go to HR and she should report this and told her multiple different avenues to take to intervene in the situation but that's the only place. Of course, she's not a physician. She was a therapist who was working with the family practice department.**
Q. Having reviewed her notes in the process of

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providing treatment, do you think that advising Sala to report to HR or follow company protocols is a healthy thing for her to do?

MS. CALEM: Objection.

**A. Yeah. Well, I mean, I think, yeah, ordinarily good advice to be given but I'm not -- Yeah. I don't know what all the issues are here, but.**

Q. Okay. And in terms of, I see that the last note that you have is September 13th of 2018, and it indicates that therapy is not recommended -- or not indicated at this time. Why would -- I'm looking over here on page 4 under the treatment plan.

**A. Uh-huh.**

Q. Why -- why isn't therapy recommended or indicated at this time?

**A. Well, I think that therapy isn't indicated in, like, a generic term or, like, for the disorder that she has or wouldn't ordinarily help. I think they're meaning the communication barrier is too great --**

Q. Okay.

**A. -- to be able to make therapy work.**

MS. POCHOP: Thank you. I don't have anything further.

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MS. CALEM: I just want to follow up on one thing.

EXAMINATION BY MS. CALEM:

Q. You said that you think the residents would say that something happened at work that was causing her distress?

**A. Yes.**

Q. Can you tell me precisely the basis for that statement? You can look through your records if you want. What is it that they said that indicated that?

**A. Well, just describing what she had told them, basically.**

Q. So it's based on her reporting, correct?

**A. Yes, correct.**

Q. They did not independently corroborate any of this?

**A. No.**

Q. Is there a particular report that you're referring to in which there's a reference to something happening at work?

**A. Well, there's more than one report. And if you want me to, I can go through and pick it out exactly who said what, but there's several people who made references to things happening at work.**

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Q. And based on what she told them?

**A. Yes.**

MS. CALEM: Nothing further.

MS. POCHOP: I don't have anything further.

MS. CALEM: Thank you very much for your time.

MS. MARSO: Do you want to read and sign or waive the reading and signing? Do you know what that means?

THE WITNESS: Yes.

MS. MARSO: I think I want to waive the reading and signing.

* * *

(Deposition concluded at 6:19 p.m., 9-24-18.)

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STATE OF SOUTH DAKOTA)
CERTIFICATE
COUNTY OF MINNEHAHA )

I, Suzanne Brudigan, Court Reporter and Notary Public within and for the State of South Dakota:

DO HEREBY ATTEST that the witness was first duly sworn by me to testify to the truth, the whole truth, and nothing but the truth relative to the matter under consideration, and that the foregoing pages 1-67, inclusive, are a true and correct transcript of my stenotype notes made during the time of the taking of the deposition of this witness.

I FURTHER ASSERT that I am not an attorney for, nor related to the parties to this action, and that I am in no way interested in the outcome of this action.

In testimony whereof, I have hereunto set my hand and official seal this 30th day of September, 2018.

/s/ Suzanne Brudigan
_____
Suzanne Brudigan, Notary Public

My Commission expires 8-4-20.

## D

## N



## O



## P

## Q



## R